| Notice of Allowability | Application No. | Applicant(s) | |
|---|---|---|---|
| | 10/084,326 | ARMENTANO ET AL. | |
| | Examiner | Art Unit | |
| | Luke Gilligan | 3626 | |

*-- The MAILING DATE of this communication appears on the cover sheet with the correspondence address--*

All claims being allowable, PROSECUTION ON THE MERITS IS (OR REMAINS) CLOSED in this application. If not included herewith (or previously mailed), a Notice of Allowance (PTOL-85) or other appropriate communication will be mailed in due course. **THIS NOTICE OF ALLOWABILITY IS NOT A GRANT OF PATENT RIGHTS.** This application is subject to withdrawal from issue at the initiative of the Office or upon petition by the applicant. See 37 CFR 1.313 and MPEP 1308.

1. ☒ This communication is responsive to *9/21/07*.

2. ☒ The allowed claim(s) is/are *1-12,21-26 and 28-62*.

3. ☐ Acknowledgment is made of a claim for foreign priority under 35 U.S.C. § 119(a)-(d) or (f).
   a) ☐ All b) ☐ Some* c) ☐ None of the:
      1. ☐ Certified copies of the priority documents have been received.
      2. ☐ Certified copies of the priority documents have been received in Application No. _____ .
      3. ☐ Copies of the certified copies of the priority documents have been received in this national stage application from the International Bureau (PCT Rule 17.2(a)).

   * Certified copies not received: _____.

Applicant has THREE MONTHS FROM THE "MAILING DATE" of this communication to file a reply complying with the requirements noted below. Failure to timely comply will result in ABANDONMENT of this application.
**THIS THREE-MONTH PERIOD IS NOT EXTENDABLE.**

4. ☐ A SUBSTITUTE OATH OR DECLARATION must be submitted. Note the attached EXAMINER'S AMENDMENT or NOTICE OF INFORMAL PATENT APPLICATION (PTO-152) which gives reason(s) why the oath or declaration is deficient.

5. ☐ CORRECTED DRAWINGS ( as "replacement sheets") must be submitted.
   (a) ☐ including changes required by the Notice of Draftsperson's Patent Drawing Review ( PTO-948) attached
      1) ☐ hereto or 2) ☐ to Paper No./Mail Date _____.
   (b) ☐ including changes required by the attached Examiner's Amendment / Comment or in the Office action of Paper No./Mail Date _____.

   **Identifying indicia such as the application number (see 37 CFR 1.84(c)) should be written on the drawings in the front (not the back) of each sheet. Replacement sheet(s) should be labeled as such in the header according to 37 CFR 1.121(d).**

6. ☐ DEPOSIT OF and/or INFORMATION about the deposit of BIOLOGICAL MATERIAL must be submitted. Note the attached Examiner's comment regarding REQUIREMENT FOR THE DEPOSIT OF BIOLOGICAL MATERIAL.

**Attachment(s)**

1. ☒ Notice of References Cited (PTO-892)
2. ☐ Notice of Draftperson's Patent Drawing Review (PTO-948)
3. ☐ Information Disclosure Statements (PTO/SB/08), Paper No./Mail Date _____
4. ☐ Examiner's Comment Regarding Requirement for Deposit of Biological Material
5. ☐ Notice of Informal Patent Application
6. ☐ Interview Summary (PTO-413), Paper No./Mail Date _____ .
7. ☒ Examiner's Amendment/Comment
8. ☒ Examiner's Statement of Reasons for Allowance
9. ☐ Other _____.

## EXAMINER'S AMENDMENT

1. An examiner's amendment to the record appears below. Should the changes and/or additions be unacceptable to applicant, an amendment may be filed as provided by 37 CFR 1.312. To ensure consideration of such an amendment, it MUST be submitted no later than the payment of the issue fee.

2. Authorization for this examiner's amendment was given in a telephone interview with Irah Donner on 11/21/07.

3. The application has been amended as follows (the following set of claims will replace the previous set of pending claims in it's entirety):

1. (Currently Amended) A computer implemented and user assisted method for providing medical referrals and medical assignments to medical insurance claims, comprising:

receiving by a claim handler a reported medical insurance claim and collecting by the claim handler data related to the reported medical insurance claim;

forwarding the reported medical insurance claim and the collected data relating to the reported claim to medical referral logic;

automatically performing the medical referral logic on the reported medical insurance claim and the collected data to determine whether a medical referral is warranted based upon predetermined referral criteria;

when the medical referral is warranted, automatically forwarding the reported medical insurance claim and the collected data to a medical case management system for review by a medical case manager;

when the medical referral is not warranted, preventing the reported medical insurance claim and the collected data from being referred to the medical case management system;

when the medical referral is warranted and the reported medical insurance claim is reviewed by the medical case manager, assigning the reported medical insurance claim by the

medical case manager to a medical personnel when the assignment is warranted based upon predetermined assignment criteria;

collecting updated data relating to the reported medical insurance claim when the data changes and when the updated data is present;

performing the medical referral logic on the reported medical insurance claim and the updated collected data to determine whether a medical referral is warranted based upon the predetermined referral criteria; and

when the medical referral is warranted, automatically forwarding the reported medical insurance claim and the updated collected data to a medical case management system for review by a medical case manager to determine whether to assign the reported medical insurance claim to the medical personnel.

2. (Previously Presented) The method of claim 1, wherein the medical insurance claim is reported from a telephone reporting center to a claim service office via a claim management system.

3. (Previously Presented) The method of claim 1, wherein the medical referral logic comprises analyzing previous claims that are similar to the reported medical insurance claim and their medical referrals and assignments.

4. (Previously Presented) The method of claim 3, wherein analyzing the previous similar claims and their medical referrals and assignments comprises:

preparing a list of data elements relating to the previous similar claims;

capturing the data elements from the prepared list; and

determining when at least one of the captured data elements is populated.

5. (Currently Amended) The method of claim 1, wherein the automatically performing medical referral logic comprises:

preparing a main list of combinations of a plurality of nature of injury (NOI) data and a plurality of part of body (POB) data on which the plurality of NOI are associated;

selecting from the main list a sub-list having combinations of one of the plurality of NOI and an associated one of the plurality of POB that desire medical referral (NOI/POB);

comparing the reported claim and the collected data with the sub-list of combinations of NOI/POB; and

determining that the medical referral is warranted when the reported claim and the collected data match with at least one of the sub-list of combinations of NOI/POB.

6. (Currently Amended) The method of claim 1, wherein the automatically performing medical referral logic comprises:

assessing the reported claim and the collected data to determine whether there is at least one of an indication of anticipated surgery, and an indication of surgery already performed on the reported claim~~, or an indication of surgery both anticipated and performed~~; and

determining that the medical referral is warranted when there is at least one of the indication of anticipated surgery, and the indication of surgery already performed on the reported claim~~, or the indication of surgery both anticipated and performed~~.

7. (Currently Amended) The method of claim 1, wherein the automatically performing medical referral logic comprises:

determining whether there is a new date which disability began for the reported claim; and

determining that the medical referral is warranted when there exists the new date which disability began.

8. (Currently Amended) The method of claim 1, wherein the automatically performing medical referral logic comprises:

determining whether a sum of TT incurred, TP incurred, and medical incurred is greater than a predetermined monetary value; and

determining that the medical referral is warranted when the sum is greater than the predetermined monetary value.

9. (Currently Amended) The method of claim 1, wherein the automatically performing medical referral logic comprises:

preparing a main list of ICD-9 codes for which the medical referral is warranted;

determining whether the reported claim and the collected data include one of the ICD-9 codes in the main list of ICD-9 codes; and

determining that the medical referral is warranted when the reported claim and the collected data include one of the ICD-9 codes in the main list of ICD-9 codes.

10. (Previously Presented) The method of claim 9, wherein preparing the main list of ICD-9 codes for which the medical referral is warranted comprises:

preparing a first sub-list having selected ICD-9 codes which identify claims with significant medical issues that require medical attention; and

preparing a second sub-list having ICD-9 codes of early strategic intervention, which denote a desire to medically intervene.

11. (Previously Presented) The method of claim 1, wherein the reported claim relates to an injury sustained by an individual; and

wherein automatically performing medical referral logic comprises:

assessing the reported claim and the collected data to determine whether the injured individual has not returned to work for more than a predetermined period of time after the injury; and

determining that the medical referral is warranted when the injured individual has not returned to work for more than the predetermined period of time after the injury.

12. (Currently Amended) The method of claim 1, wherein the automatically performing medical referral logic comprises:

assessing the reported claim and the collected data to determine whether there is at least one of an indication of anticipated surgery, and an indication of surgery already performed on the reported claim~~, or an indication of surgery both anticipated and performed~~;

determining whether there is a new date which disability began for the reported claim;

determining whether a sum of TT incurred, TP incurred, and medical incurred is greater than a predetermined monetary value; and

preparing a main list of ICD-9 codes for which the medical referral is warranted.

13–20. (cancelled)

21. (Previously Presented) The method of claim 1, wherein the medical referral logic comprises specific market or employer resource information.

22. (Previously Presented) The method of claim 1, wherein the medical referral logic comprises information provided by medical team leaders in local claim service centers regarding (a) current methods of claim evaluation to determine medical referral; and (b) Special Account Communication (SAC) instructions that impact medical referral decisions.

23. (Previously Presented) The method of claim 1, wherein the medical referral logic comprises analyzing reported medical insurance claims currently being referred and assigned for medical management and claims non-intervened for medical referral.

24. (Previously Presented) The method of claim 23, wherein analyzing the reported medical insurance claims currently being referred and assigned for medical management and claims non-intervened for medical referral comprises:

preparing a list of data elements relating to the claims;

capturing the data elements from the prepared list; and

determining when at least one of the captured data elements is populated.

25. (Previously Presented) The method of claim 3 or 23, wherein analyzing the claims comprises:

reviewing one or more of actual paid value, medical incurreds, indemnity incurreds, National Council on Compensation Insurance (NCCI) codes, ICD-9 data of assigned and non-assigned claims, anticipated surgery indicator, and lost time days.

26. (Previously Presented) The method of claim 1, further comprising:

when the medical referral is warranted, preventing the reported medical insurance claim and the collected data from reaching the medical case management system if any of the following are true:

the claim is closed in the claim management system;

policy coverage is N (none) or U (unknown);

controverted indicator is Yes;

date of death is populated;

there is already an open medical case management system referral;

the policy is an opted out account;

there is a prior carrier policy or excess carrier file;

the injured worker returned to work full duty;

the injured worker will never return to work; or

the medical program of the host insurance carrier or health care plan provider is bypassed.

27. (Cancelled)

28. (Currently Amended) A computer implemented and user assisted method for providing medical referrals and medical assignments to medical insurance claims, comprising:

forwarding a reported medical insurance claim and collected data relating to the reported claim from a claim handler to medical referral logic;

automatically performing the medical referral logic on the reported medical insurance claim and the collected data to determine whether a medical referral is warranted, comprising the steps of:

(1) preparing a main list of combinations of a plurality of nature of injury (NOI) data and a plurality of part of body (POB) data on which the plurality of NOI are associated;

selecting from the main list a sub-list having combinations of one of the plurality of NOI and an associated one of the plurality of POB that desire medical referral (NOI/POB);

comparing the reported claim and the collected data with the sub-list of combinations of NOI/POB; and

determining that the medical referral is warranted when the reported claim and the collected data match with at least one of the sub-list of combinations of NOI/POB, and

(2) assessing the reported claim and the collected data to determine whether there is at least one of an indication of anticipated surgery, and an indication of surgery

already performed on the reported claim~~, or an indication of surgery both anticipated and performed~~; and

determining that the medical referral is warranted when there is at least one of the indication of anticipated surgery, and the indication of surgery already performed on the reported claim~~, or the indication of surgery both anticipated and performed~~, and

(3) assessing the reported claim and the collected data to determine whether the injured individual has not returned to work for more than a predetermined period of time after the injury; and

determining that the medical referral is warranted when the injured individual has not returned to work for more than the predetermined period of time after the injury;

when the medical referral is warranted, automatically forwarding the reported medical insurance claim and the collected data to a medical case management system for review by a medical case manager;

when the medical referral is not warranted, preventing the reported medical insurance claim and the collected data from reaching the medical case management system; and

when the medical referral is warranted and the reported medical insurance claim is reviewed by the medical case manager, assigning the reported medical insurance claim by the medical case manager to a medical personnel when the assignment is warranted based upon predetermined assignment criteria.

29. (Currently Amended) A computer implemented and user assisted method for providing medical referrals and medical assignments to medical insurance claims, comprising:

forwarding a reported medical insurance claim and collected data relating to the reported claim from a claim handler to medical referral logic;

automatically performing the medical referral logic on the reported medical insurance claim and the collected data to determine whether a medical referral is warranted based upon predetermined referral criteria;

when the medical referral is warranted, automatically forwarding the reported medical insurance claim and the collected data to a medical case management system for review by a medical case manager;

when the medical referral is not warranted, preventing the reported medical insurance claim and the collected data from being referred to the medical case management system; and

when the medical referral is warranted and the reported medical insurance claim is reviewed by the medical case manager, assigning the reported medical insurance claim by the medical case manager to a medical personnel when the assignment is warranted based upon predetermined assignment criteria and not assigning the reported medical insurance claim by the medical case manager to medical personnel when any of the following is true:

when account instructions are present, and when the account instructions indicate that a customer does not want medical assignment; or

the claim is a catastrophic claim or severe injury.

30. (Previously Presented) The method of claim 1, 28, or 29 wherein the reported medical insurance claim is from a workers compensation insurance carrier, a health insurance carrier, or a health care plan provider.

31. (Previously Presented) The method of claim 1, further comprising seeking by the medical case manager pre-approval for medical assignment.

32. (Currently Amended) The method of claim 1, further comprising:

when the medical referral is warranted and the reported medical insurance claim is reviewed by the medical case manager, non-intervening and not assigning the reported medical insurance claim by the medical case manager to a medical personnel when any of the following is true:

the claim does not meet medical assignment criteria;

the account instructions indicate that ~~the~~ a customer does not want medical assignment; or

the claim is a catastrophic claim or severe injury.

33. (Previously Presented) The method of claim 1, further comprising:

forwarding by the claim handler a reported medical insurance claim and collected data relating to the reported claim to a medical case management system for review by a medical case manager.

34. (Previously Presented) The method of claim 1, further comprising:

generating one or more management information reports based on milestones created when certain system activities take place.

35. (Previously Presented) The method of claim 1, wherein when the medical referral is warranted and the reported medical insurance claim is reviewed by the medical case manager, preventing the reported medical insurance claim by the medical case manager from being assigned to the a medical personnel when the assignment is not warranted.

36. (New) The method of claim 28, wherein the automatically performing medical referral logic comprises:

assessing the reported claim and the collected data to determine whether there is at least one of an indication of anticipated surgery, and an indication of surgery already performed on the reported claim; and

determining that the medical referral is warranted when there is at least one of the indication of anticipated surgery, and the indication of surgery already performed on the reported claim.

37. (New) The method of claim 28, wherein the medical referral logic comprises:

determining whether there is a new date which disability began for the reported claim; and

determining that the medical referral is warranted when there exists the new date which disability began.

38. (New) The method of claim 28, wherein the medical referral logic comprises:

determining whether a sum of TT incurred, TP incurred, and medical incurred is greater than a predetermined monetary value; and

determining that the medical referral is warranted when the sum is greater than the predetermined monetary value.

39. (New) The method of claim 28, wherein the medical referral logic comprises:

preparing a main list of ICD-9 codes for which the medical referral is warranted;

determining whether the reported claim and the collected data include one of the ICD-9 codes in the main list of ICD-9 codes; and

determining that the medical referral is warranted when the reported claim and the collected data include one of the ICD-9 codes in the main list of ICD-9 codes.

40. (New) The method of claim 39, wherein the preparing the main list of ICD-9 codes for which the medical referral is warranted comprises:

preparing a first sub-list having selected ICD-9 codes which identify claims with significant medical issues that require medical attention; and

preparing a second sub-list having ICD-9 codes of early strategic intervention, which denote a desire to medically intervene.

41. (New) The method of claim 28, wherein the reported claim relates to an injury sustained by an individual; and

wherein the automatically performing medical referral logic comprises:

assessing the reported claim and the collected data to determine whether the injured individual has not returned to work for more than a predetermined period of time after the injury; and

determining that the medical referral is warranted when the injured individual has not returned to work for more than the predetermined period of time after the injury.

42. (New) The method of claim 28, wherein the automatically performing medical referral logic comprises:

assessing the reported claim and the collected data to determine whether there is at least one of an indication of an anticipated surgery, and an indication of surgery already performed on the reported claim;

determining whether there is a new date which disability began for the reported claim;

determining whether a sum of TT incurred, TP incurred, and medical incurred is greater than a predetermined monetary value; and

preparing a main list of ICD-9 codes for which the medical referral is warranted.

43. (New) The method of claim 28, wherein the medical referral logic comprises information provided by medical team leaders in local claim service centers regarding (a) current methods of claim evaluation to determine medical referral; and (b) Special Account Communication (SAC) instructions that impact medical referral decisions.

44. (New) The method of claim 28, wherein the medical referral logic comprises analyzing reported medical insurance claims currently being referred and assigned for medical management and claims non-intervened for medical referral.

45. (New) The method of claim 44, wherein the analyzing the reported medical insurance claims currently being referred and assigned for medical management and claims non-intervened for medical referral comprises:

preparing a list of data elements relating to the claims;

capturing the data elements from the prepared list; and

determining when at least one of the captured data elements is populated.

46. (New) The method of claim 28, further comprising:

when the medical referral is warranted, preventing the reported medical insurance claim and the collected data from reaching the medical case management system if any of the following are true:

the claim is closed in the claim management system;

policy coverage is N (none) or U (unknown);

controverted indicator is Yes;

date of death is populated;

there is already an open medical case management system referral;

the policy is an opted out account;

there is a prior carrier policy or excess carrier file;

the injured worker returned to work full duty;

the injured worker will never return to work; or

the medical program of the host insurance carrier or health care plan provider is bypassed.

47. (New) The method of claim 28, further comprising:

when the medical referral is warranted and the reported medical insurance claim is reviewed by the medical case manager, non-intervening and not assigning the reported medical insurance claim by the medical case manager to a medical personnel when any of the following is true:

the claim does not meet medical assignment criteria;

the account instructions indicate that a customer does not want medical assignment; or

the claim is a catastrophic claim or severe injury.

48. (New) The method of claim 28, further comprising:

forwarding by the claim handler a reported medical insurance claim and collected data relating to the reported claim to a medical case management system for review by a medical case manager.

49. (New) The method of claim 28, further comprising:

generating one or more management information reports based on milestones created when certain system activities take place.

50. (New) The method of claim 29, wherein the medical referral logic comprises:

assessing the reported claim and the collected data to determine whether there is at least one of an indication of an anticipated surgery, and an indication of surgery already performed on the reported claim; and

determining that the medical referral is warranted when there is at least one of the indication of an anticipated surgery, and the indication of surgery already performed on the reported claim.

51. (New) The method of claim 29, wherein the automatically performing medical referral logic comprises:

determining whether there is a new date which disability began for the reported claim; and

determining that the medical referral is warranted when there exists the new date which disability began.

52. (New) The method of claim 29, wherein the automatically performing medical referral logic comprises:

determining whether a sum of TT incurred, TP incurred, and medical incurred is greater than a predetermined monetary value; and

determining that the medical referral is warranted when the sum is greater than the predetermined monetary value.

53. (New) The method of claim 29, wherein the automatically performing medical referral logic comprises:

preparing a main list of ICD-9 codes for which the medical referral is warranted;

determining whether the reported claim and the collected data include one of the ICD-9 codes in the main list of ICD-9 codes; and

determining that the medical referral is warranted when the reported claim and the collected data include one of the ICD-9 codes in the main list of ICD-9 codes.

54. (New) The method of claim 53, wherein preparing the main list of ICD-9 codes for which the medical referral is warranted comprises:

preparing a first sub-list having selected ICD-9 codes which identify claims with significant medical issues that require medical attention; and

preparing a second sub-list having ICD-9 codes of early strategic intervention, which denote a desire to medically intervene.

55. (New) The method of claim 29, wherein the reported claim relates to an injury sustained by an individual; and

wherein the automatically performing medical referral logic comprises:

assessing the reported claim and the collected data to determine whether the injured individual has not returned to work for more than a predetermined period of time after the injury; and

determining that the medical referral is warranted when the injured individual has not returned to work for more than the predetermined period of time after the injury.

56. (New) The method of claim 29, wherein the automatically performing medical referral logic comprises:

assessing the reported claim and the collected data to determine whether there is at least one of an indication of an anticipated surgery, and an indication of surgery already performed on the reported claim;

determining whether there is a new date which disability began for the reported claim;

determining whether a sum of TT incurred, TP incurred, and medical incurred is greater than a predetermined monetary value; and

preparing a main list of ICD-9 codes for which the medical referral is warranted.

57. (New) The method of claim 29, wherein the medical referral logic comprises information provided by medical team leaders in local claim service centers regarding (a) current methods of claim evaluation to determine medical referral; and (b) Special Account Communication (SAC) instructions that impact medical referral decisions.

58. (New) The method of claim 29, wherein the medical referral logic comprises analyzing reported medical insurance claims currently being referred and assigned for medical management and claims non-intervened for medical referral.

59. (New) The method of claim 58, wherein the analyzing the reported medical insurance claims currently being referred and assigned for medical management and claims non-intervened for medical referral comprises:

preparing a list of data elements relating to the claims;

capturing the data elements from the prepared list; and

determining when at least one of the captured data elements is populated.

60. (New) The method of claim 29, further comprising:

when the medical referral is warranted, preventing the reported medical insurance claim and the collected data from reaching the medical case management system if any of the following are true:

the claim is closed in the claim management system;

policy coverage is N (none) or U (unknown);

controverted indicator is Yes;

date of death is populated;

there is already an open medical case management system referral;

the policy is an opted out account;

there is a prior carrier policy or excess carrier file;

the injured worker returned to work full duty;

the injured worker will never return to work; or

the medical program of the host insurance carrier or health care plan provider is bypassed.

61. (New) The method of claim 29, further comprising:

forwarding by the claim handler a reported medical insurance claim and collected data relating to the reported claim to a medical case management system for review by a medical case manager.

62. (New) The method of claim 29, further comprising:

generating one or more management information reports based on milestones created when certain system activities take place.

***Allowable Subject Matter***

4. Claims 1-12, 21-26, and 28-62 are allowed. The following is an examiner's statement of reasons for allowance: The primary reason for the allowance of claims 1-12, 21-26, and 30-35 is the inclusion of the limitations in all of the claims that is not found in the prior art of automatically forwarding a reported medical insurance claim to a medical case manager based on the

automatic determination of whether a medical referral is warranted, assigning the claim by the medical case manager to a medical personnel based on assignment criteria, then performing an additional determination of referral and assignment based on collected updated data. The closest prior art (Colburn et al., U.S. Patent Application Publication No. 2001/0044735 and Sabovich, U.S. Patent Application No. 2002/0138306) teaches automatic determination of how to handle a medical insurance claim based on collected data relating to the claim and recommendations for further interventions relating to a particular claim (Colburn) along with determining how whether to route a medical claim to an insurance company based on predefined treatment protocols (Sabovich). However, none of the prior art individually or collectively teaches the subsequent determination of referral and assignment based on collected updated data after an initial determination of referral and assignment of a medical insurance claim.

5. The primary reason for the allowance of claims 28, 30, and 36-49 is the inclusion of the limitations in all of the claims that is not found in the prior art of automatically forwarding a reported medical insurance claim to a medical case manager based on the automatic determination of whether a medical referral is warranted, assigning the claim by the medical case manager to a medical personnel based on assignment criteria, where determining whether a medical referral is warranted is based on the claimed 3 step process. As described above, Colburn and Sabovich teach automatic determination of how to handle a medical insurance claim based on collected data relating to the claim and recommendations for further interventions relating to a particular claim along with determining how whether to route a medical claim to an insurance company based on predefined treatment protocols. However, the prior art fails to teach claimed 3 step process for determining whether a medical assignment is warranted.

6. The primary reason for the allowance of claims 229, 30, and 50-62 is the inclusion of the limitations in all of the claims that is not found in the prior art of automatically forwarding a reported medical insurance claim to a medical case manager based on the automatic determination of whether a medical referral is warranted, assigning the claim by the medical case manager to a medical personnel based on assignment criteria, but not assigning the claim to a medical personnel if account instructions indicate that a customer does not want a medical assignment or if the claim is a catastrophic claim or severe injury. As described above, Colburn and Sabovich teach automatic determination of how to handle a medical insurance claim based on collected data relating to the claim and recommendations for further interventions relating to a particular claim along with determining how whether to route a medical claim to an insurance company based on predefined treatment protocols. However, the prior art fails to teach assigning the medical insurance claim to medical personnel after a medical referral has already been conducted but not assigning the claim based on the criterion of account instructions indicate that a customer does not want a medical assignment or if the claim is a catastrophic claim or severe injury.

7. In addition, the previously cited AIG and Larking references teach utilizing medical assignment criteria to determine whether to assign a medical insurance claim. However, neither of these references teach a previous process of automatically determining whether to first refer a medical insurance claim to a case manager prior to determining whether to assign the claim. Therefore, the claims distinguish over these prior art references as well.

8. Any comments considered necessary by applicant must be submitted no later than the payment of the issue fee and, to avoid processing delays, should preferably accompany the issue fee. Such submissions should be clearly labeled "Comments on Statement of Reasons for Allowance."

***Conclusion***

9. Any inquiry concerning this communication or earlier communications from the examiner should be directed to Luke Gilligan whose telephone number is (571) 272-6770. The examiner can normally be reached on Monday-Friday 8am-5:30pm.

10. If attempts to reach the examiner by telephone are unsuccessful, the examiner's supervisor, Joseph Thomas can be reached on (571) 272-6776. The fax phone number for the organization where this application or proceeding is assigned is 571-273-8300.

11. Information regarding the status of an application may be obtained from the Patent Application Information Retrieval (PAIR) system. Status information for published applications may be obtained from either Private PAIR or Public PAIR. Status information for unpublished applications is available through Private PAIR only. For more information about the PAIR system, see http://pair-direct.uspto.gov. Should you have questions on access to the Private PAIR system, contact the Electronic Business Center (EBC) at 866-217-9197 (toll-free). If you would like assistance from a USPTO Customer Service Representative or access to the automated information system, call 800-786-9199 (IN USA OR CANADA) or 571-272-1000.

11/25/07

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